INTRODUCTION:	CanaRxMeds is an optional mail order program for employees and their covered dependents who are insured through the following West Suburban Health Group plans: Network Blue HMO, Network Blue Options HMO Rate Saver, Blue Cross Blue Shield Benchmark Plan, Harvard Pilgrim HMO, Harvard Pilgrim HMO Rate Saver, Harvard Pilgrim PPO, Harvard Pilgrim Choicenet Benchmark Plan, Tufts Health Plan EPO, Tufts Health Plan EPO Rate Saver, Tufts Health Plan POS, or Tufts Health Plan Benchmark Plan. When ordering your new medications, please allow 20 business days for delivery.
CO-PAYMENTS:	All member co-payments have been waived for this program only.
ORDERING INSTRUCTIONS:	To place your order, we require a completed Medication Record Form, as well as a prescription for each medication. Please ask your doctor to specify a **3-month supply** with **3 refills** on each prescription. This will allow our Pharmacies to ***automatically ship*** your medications after confirming your continued need.
	COMPLETED MEDICATION RECORD FORMS MAY BE SUBMITTED BY: A. FAXING TOLL FREE TO: 1-866-715-6337 B. MAILING TO: CanaRx Group P.O. Box 44650 Detroit, MI 48244-0650 **NOTE**: The Medication Record and the prescriptions should arrive together. If you need to order new medications later in the year, you will need to send an updated Medication Record; then simply have your doctor fax the prescription directly, with your health plan number (from your card) written on the prescription.
	PRESCRIPTIONS MAY BE SUBMITTED BY: A. FAXING TOLL FREE TO: 1-866-715-6337 **DIRECTLY FROM YOUR DOCTOR'S OFFICE ONLY** B. MAILING TO: CanaRx Group P.O. Box 44650 Detroit, MI 48244-0650
SERVICE INFORMATION:	Additional forms may be obtained from your employer, online at **www.myMedicationAdvisor.com**, or by calling the ***myMedicationAdvisor***® HelpLine at (877) 467-3113.

Thank you for participating in this program. Our goal is your total satisfaction.
Please do not hesitate to bring any questions or concerns to our attention.
Call CanaRxMeds at 1-866-893-6337.

CONFIRMATION AND REPRESENTATIONS

I, the undersigned, am entering into this agreement with *CanaRx Group Inc. ("CanaRx")* in order that I may obtain access to medically necessary prescription drugs at low costs.

1. I am of the age of majority in the jurisdiction in which I ordinarily reside;
2. I am not restricted from making my own medical decisions under the laws of the jurisdiction in which I ordinarily reside;
3. The medications that I have requested that CanaRx facilitate my obtaining were prescribed by a duly qualified and licensed medical practitioner in the United States;
4. I have not violated any laws in the jurisdiction in which I ordinarily reside, in obtaining the prescription for the ordered product;
5. This prescription has not been altered in any way nor has it been filled previously. I agree to mail or fax from my doctor's office the original copy of the prescription to CanaRx;
6. I am under the ongoing care of a physician in my residing jurisdiction (my "U.S. physician"), and therefore, I am not seeking or relying on any medical information from CanaRx or any CanaRx contracted physician;
7. My prescription will not be used in any way whatsoever except as prescribed by my medical practitioner who originally issued the prescription;
8. I will not permit anyone else to use the prescription or any medications which I receive;
9. I will use any medications obtained for me by CanaRx strictly in accordance with the instructions provided by the physician who prescribed the medications; and
10. In the event that I suffer any side effects from any medications I receive through the services of CanaRx, I will immediately contact my U.S. physician.
11. I certify that I am a resident of the United States and not a resident of any other country.

AUTHORIZATION AND CONSENT

I further provide my authorization and consent to the following:

1. I hereby appoint CanaRx and its delegates or contractors as my paid agent and attorney for the purposes of obtaining prescriptions which correspond to the prescriptions provided by my U.S. physician.
2. I authorize CanaRx and its delegates or contractors to arrange the purchase and delivery of the medications prescribed to me on the terms outlined in this agreement and to the same extent as if I personally took such steps.
3. I consent and authorize CanaRx to collect my personal medical information and to maintain on file the information necessary to verify and process future orders, including but not limited to my full name, address, phone number, complete medical history and payment information.
4. I authorize my U.S. physician and CanaRx to release any and all information required in connection with my physical condition, including but not limited to all X-rays, medical records, medical reports, progress notes, nurses' notes, reports on diagnostic tests, medical opinions and/or any other knowledge or information which they may possess to a CanaRx contracted physician who may be required to review my health record for the purposes of being in a position to evaluate the medical necessity and indications for prescription medication.
5. I authorize the CanaRx contracted physician to contact my U.S. physician to discuss my prescription if necessary.
6. I further authorize the CanaRx contracted physician to issue prescriptions for medications I have ordered only if he/she deems it advisable and appropriate.
7. I further authorize the CanaRx contracted physician to release any and all information that may be required by any CanaRx contracted pharmacy for the purpose of having my prescriptions filled.
8. I further authorize CanaRx to make payments on my behalf to the CanaRx contracted pharmacy for the filling of my prescriptions and to the CanaRx contracted physician **for services rendered on my behalf.**

ACKNOWLEDGEMENT AND RELEASE

I hereby make the following acknowledgments and releases to *CanaRx*, including all of its employees, its contractors, including physicians, pharmacists, pharmacy technicians, nurses, receptionists and staff:

1. I acknowledge that my U.S. physician is my primary physician and the CanaRx contacted physician is being asked only to review the information contained in the Personal Medical History for the purpose of authorizing any properly prescribed medications for fulfillment from a CanaRx contracted pharmacy.
2. I acknowledge that CanaRx has made no representations or warranties to me, including, without limitation, representations or warranties regarding the use of fitness for any particular purpose of the medications delivered (including, without limitation, its appropriateness for curing or helping relieve any particular ailment, illness or disease, or its potential or actual side or adverse effects whether previously known or unknown).
3. I acknowledge that I wish to obtain a prescription from a CanaRx contracted physician and have enlisted the services of CanaRx to facilitate this matter. I understand and appreciate that the CanaRx contracted physician will rely on the accuracy of the examination and prescription provided by my U.S. physician.
4. I hereby specifically acknowledge that I am aware that CanaRx may transmit my personal information by electronic means (for example fax, or secure internet) to its agents, contracted physicians and pharmacies. I understand that the use of electronic means will enhance the efficiency and timeliness of processing my order. I also understand that CanaRx, as a custodian of my personal information, will take all appropriate precautions to protect my personal information from improper disclosure or use. I hereby consent to CanaRx's transmission of my personal information by electronic means to its agents, contracted physicians and pharmacies.
5. I acknowledge that child protective packaging may not be used by the CanaRx contracted pharmacy filling my prescription and I release CanaRx and all of their officers and directors, agents, employees and contractors from any and all causes of action with respect to errors or omissions by the company or agency responsible for transporting my order.
6. I acknowledge that I have purchased my medications internationally for personal use and understand that my medications may be subject to U.S. border seizure. I specifically confirm, acknowledge and agree that title to my medication passes to me when my medications are shipped from the CanaRx contracted pharmacy.
7. I acknowledge that CanaRx, as my paid agent, requires payment in full prior to shipment and that my order may not be returned for a refund or an exchange. All member co-payments have been waived for this program only.

MY MEDICATION ADVISOR®

Medication Record Form

FAX DIRECTLY FROM YOUR DOCTOR'S OFFICE WITH YOUR PRESCRIPTION(S). **FAX: TOLL FREE 1-866-715-6337**
OR MAIL TO: CanaRx Group, P.O. Box 44650, Detroit, MI 48244-0650 **TEL: TOLL FREE 1-866-893-6337**

PERSONAL INFORMATION

Full Name *(please print)*: _____

This person *is* *(select one)*: ☐ subscriber ☐ spouse ☐ dependent **Date of Birth:** ____ ____ - ____ ____ - ____ ____

Gender: ☐ Male ☐ Female **Height:** _____' _____" **Weight:** _____ pounds

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____ **Telephone:** _____

E-Mail: _____ **Employer:** West Suburban Health Group

PATIENT HEALTH INFORMATION

Note: Each prescription should request a **3-month** supply of medications with **3 refills** indicated. **New-to-you** medications should be tried for a period of **30-days** before ordering through CanaRx Group Inc. You may be contacted by one of our representatives or the pharmacy filling the prescription to discuss or confirm your order.

Health Plan Identification Number: _____ **Health Plan Name:** _____

Operations: (e.g., Hysterectomy, Gall Bladder, Heart Operations, etc.) _____

_____

Hospitalizations: (stays in hospital past 5 years) _____

_____

Current Medical Conditions: _____

_____

OVER-THE-COUNTER MEDICATIONS/HERBAL REMEDIES
☐ **NO** ☐ **YES If yes, please specify:**

_____
_____
_____

MEDICATION/FOOD ALLERGIES
☐ **NO** ☐ **YES If yes, please specify:**

_____
_____
_____

PRESCRIPTION MEDICATION LIST

Please be sure that all fields below are entered completely.

Name of Medicine	Reason for Taking	Dosage	Date Started	Time(s) to Take	What to Avoid	Doctor Name
*ex:*Lipitor	*ex*:Cholesterol	*ex*:25mg	*ex*:1/1/2000	*ex:*Twice daily	*ex*:grapefruit	*ex*: Dr.Smith

If you have additional medications to enter, please use an additional Medication Record Form and check here ☐

AUTHORIZATION: I certify this to be a true and accurate statement of the above Patient's Medical History. I confirm that he/she has been and will continue to be regularly monitored by a U.S. Physician and has had a physical examination within the past 12 months. I certify that I have read and understand the terms of agreements for both CanaRx and myMedicationAdvisor.com and that the information provided by me is accurate and true.

I request and authorize my Employer to pay for any and all services, fees and amounts relating to the prescription medications that I will obtain through this service. A Guardian/Parent ***must sign*** for an Underage Dependent.

_____ _____ _____
Patient Name (please print): Signature Date

_____ _____ _____
Subscriber/Guardian, if applicable (please print): Signature Date

THIS FORM *MUST BE* ACCOMPANIED WITH THE WRITTEN PRESCRIPTIONS OF YOUR U.S. PHYSICIAN.